



**DEPARTMENT OF VETERANS AFFAIRS
NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEM**

Omaha
4101 Woolworth Avenue
Omaha NE 68105-1873

Lincoln
600 S 70th Street
Lincoln NE 68510-2493

Grand Island
2201 N Broadwell Avenue
Grand Island NE 68803-2196

In Reply Refer To: 636/002

August 17, 2011

Alex Willford
Grand Island State Veterans Home
2300 W. Capitol Ave
Grand Island, NE 68803

Dear Mr. Willford:

The VA Nebraska Western Iowa Health Care System Survey Team conducted the annual survey of the Grand Island State Veterans Home on June 7- 9, 2011.

The VAMC Survey Team identified one domiciliary and two nursing home standards that were not in compliance with VA standards. You were notified in writing of these findings on July 11, 2011.

On July 22, 2011, you responded with the Grand Island Veterans Home's corrective action plan. After the survey team reviewed the evidence of implementation of the corrective action plan, it is determined that your facility is in compliance with all VA standards. We have granted Grand Island State Veterans Home full certification for Nursing Home and Domiciliary for 2011-2012.

Thank you for your continued service to our nation's Veterans.

Sincerely,

A handwritten signature in cursive script, reading "Nancy A. Gregory".

Nancy A. Gregory FACHE
Acting Director
Nebraska Western Iowa

A handwritten signature in cursive script, reading "Jorge I. Ramirez".

Jorge I. Ramirez, MD, FAAHPM
Acting Director VISN 23
Extended Care and Rehab Service Line

cc: John Hilgert, Nebraska Department of Veterans Affairs
cc: Janet P. Murphy, Network Director, VISN 23
cc: James Burris MD, Chief Consultant, VA Geriatrics and Extended Care
cc: Chief Network Officer (10N)

**DEPARTMENT OF VETERANS AFFAIRS
NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEMS
ANNUAL SURVEY - 2011**

GRAND ISLAND VETERANS' HOME

PHYSICAL ENVIRONMENT		
Inspector determines that the nursing home failed to:	Inspection Date	Date of Correction
Provide evidence that reported life safety deficiencies have been or are being corrected.	06/09/2011	06/30/2011
PHARMACY SERVICES		
Inspector determines that the nursing home failed to:	Inspection Date	Date of Correction
Report any irregularities from review of drug regimen to the primary physician and the director of nursing, and act upon them.	06/09/2011	07/31/2011